



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

NUEVA VIDA BEHAVIORAL HEALTH AND ASSOC.

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-3380-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

JULY 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: On 4/7/14, Licensed Professional Counselor, Andrea Zuflacht, M.S., L.P.C. (Nueva Vida Behavioral Clinical Director) met with [Claimant's] treating physician Dr. Douglas Burke DC., and Erica Contreras BA., to coordinate his plan of care."

Amount in Dispute: \$28.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The documentation for this date tracks to care coordination and coordinating care yet there is no explanation as to what is being coordinated. No payment is due."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 7, 2014	CPT Code 99361 Case Management Services	\$28.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-W1-Workers compensation state fee schedule adjustment.
 - 744-Does not meet the definition of case management per DWC rule 134.202 and/or 134.204.
 - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
 - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 891-No additional payment after reconsideration.

Issues

Did the requestor support billing the medical conference in accordance with 28 Texas Administrative Code §134.204? Is the requestor entitled to reimbursement?

Findings

The respondent denied reimbursement for the case management services, CPT code 99361, based upon reason code "744."

28 Texas Administrative Code §134.204(e)(1)(B) states "Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call."

A review of the submitted CASE MANAGEMENT NOTE reports finds that the requestor noted on the CASE MANAGEMENT NOTE reports that the "General Purpose: Care Coordination X." Under the heading "Specific Purpose: Coordinating Care X." The requestor's check list does not explain what care was being coordinated.

The respondent states "The requestor billed code 99361 for services provided 4/7/14. (See requestor's DWC-60 packet.) Rule 134.204(e)(3) states 'coordinating with the employer, employee, or an assigned medical or vacation case manager to determine return to work options; (B) developing or revising a treatment plan, including any treatment plans required by Division rules; (C) altering or clarifying previous instructions; or (D) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties.' The documentation for this date tracks to care coordination and coordinating care yet there is no explanation as to what is being coordinated."

28 Texas Administrative Code §134.204(e)(2) states: "Case Management Responsibilities by the Treating Doctor is as follows: Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee."

28 Texas Administrative Code §134.204(e)(4) states "Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows: (A) CPT Code 99361.

- (i) Reimbursement to the treating doctor shall be \$113. Modifier "W1" shall be added.
- (ii) Reimbursement to the referral HCP shall be \$28 when a HCP contributes to the case management activity."

Review of the submitted CASE MANAGEMENT NOTE reports finds that the requestor listed the participants in the conference. The documentation does not support that the case management was triggered by a documented change in the injured employee's condition per by 28 Texas Administrative Code §134.204(e)(2). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

02/26/2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.